

5.4.3 FAMILY WELFARE

118. India, the second most populous country in the world, has no more than 2.5 per cent of global land but is the home of 1/6th of the world's population. The prevailing high maternal, infant, childhood morbidity and mortality, low life expectancy and high fertility and associated high morbidity had been a source of concern for public health professionals right from the pre-independence period. The Bhore Committee Report (1946) which laid the foundation for health service planning in India, gave high priority to provision of maternal and child health services and improving their nutritional and health status. Right in 1951 it was recognised that population stabilisation is an essential prerequisite for sustainability of development process so that the benefits of economic development result in enhancement of the well being of the people and improvement in quality of life. India became the first country in the world to formulate a National Family Planning Programme in 1952, with the objective of “reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy”. Thus, the key elements of health care to women and children and provision of contraceptive services have been the focus of India's health services right from the time of India's independence. Successive Five Year Plans have been providing the policy framework and funding for planned development of nationwide health care infrastructure and manpower. The Centrally Sponsored and 100 per cent centrally funded Family Welfare Programme provides additional infrastructure, manpower and consumables needed for improving health status of women and children and to meet all the felt needs for fertility regulation.

DEMOGRAPHIC TRANSITION – OPPORTUNITIES AND CHALLENGES

119. The technological advances and improved quality and coverage of health care resulted in a rapid fall in Crude Death Rate (CDR) from 25.1 in 1951 to 9.8 in 1991. In contrast, the reduction in Crude Birth Rate (CBR) has been less steep, declining from 40.8 in 1951 to 29.5 in 1991. As a result, the annual exponential population growth rate has been over 2 per cent between 1960-1990. Census 1991 showed that India was entering the phase when there will be progressive decline in population growth rate. The rate of decline in birth rate and population growth is likely to be further accelerated in the next decade. The changes in the population growth rates in India have been relatively slow, but the change has been steady and sustained. As a result the country was able to achieve a relatively gradual change in the population numbers and age structure. The short and long term adverse consequences of too rapid decline in birth rates and change in age structure on the social and economic development were avoided and the country was able to adapt to these changes without massive disruption in development efforts.

Population Projections

120. Census 1991 recorded that the population of the country was 846.3 million. The population will increase from 934 million in 1996 to 1264 million in 2016. In spite of the uniform national norms set under the 100 per cent Centrally Funded and Centrally Sponsored Scheme (CSS) of Family Welfare, there are substantial differences in fertility and mortality between States. At one end of the spectrum is Kerala with mortality and fertility rates nearly similar to those in some of the developed countries. At the other end, there are States such as Uttar Pradesh, Bihar, Madhya Pradesh Rajasthan and Orissa with high Infant Mortality Rate and Fertility Rates.

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121. The five States of Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and Orissa, which constitute 44 per cent of the total population of India in 1996, will constitute 48 per cent of the total population of India in 2016. These states will contribute 55 per cent of the total increase in population of the country during the period 1996-2016. The progress in these states would determine the year and size of the population at which the country achieves population stabilisation. Urgent energetic steps are required to be initiated to assess and fully meet the unmet needs for maternal and child health (MCH) care and contraception through improvement in availability and access to family welfare services in the States of Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar in order to achieve a faster decline in their mortality and fertility rates.

122. In the current century nearly half the population of India will be residing in the State of Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan and Orissa. In all the States performance in all the social and economic sector has been poor. The poor performance is the outcome of poverty, illiteracy, lack of organised services to meet the people's needs and poor development which co-exist and reinforce each other. These states have excellent human, mineral and agricultural potential. While the southern and the Western states have achieved substantial proportion of their potential, the potential of the Northern and North Eastern States have been as yet not fully utilised. Human, social and economic development of the country in the present century will to a large extent depend upon these States fully realising their full potential. It is imperative that all steps are taken to ensure that these States achieve their full potential in the shortest possible through planned coordinated efforts from all sectors.

123. The Report of the Technical Group on Population Projections has estimated the probable year by which replacement level TFR of 2.1 will be achieved by different states and India if the recent pace of decline in TFRs observed during 1985-93 or 1981-93 continues in the years ahead (Table 5.4.3.1).

TABLE 5.4.3.1
Year By Which TFR of 2.1 Will Be Achieved

	Year by Which Projected TFR will be 2.1
India	2026 *
Andhra Pradesh	2002
Assam	2015
Bihar	2039
Gujarat	2014
Haryana	2025
Karnataka	2009
Kerala	Achieved In 1988
Madhya Pradesh	Beyond 2060
Maharashtra	2008
Orissa	2010
Punjab	2019
Rajasthan	2048
Tamil Nadu	Achieved In 1993
Uttar Pradesh	Beyond 2100
West Bengal	2009

- Based On Pooled Estimates Of TFR.

124. Goa with relatively high income, literacy and good health care infrastructure was the first administrative unit to achieve the replacement level of fertility. This fitted the classical theory that allowed socio-economic development with decline in fertility; Goa and Pondicherry have been having less than replacement level fertility for over a decade. Kerala, the first State to achieve replacement level of fertility (TFR of 2.1) did so in spite of relatively low per capita income. High status of women, female literacy, age at marriage and low infant mortality were thought to be the factors behind the rapid fall in fertility in Kerala, Tamil Nadu which was the second state to achieve replacement level of fertility did so in spite of low PCI, higher IMR and lower female literacy rate than Kerala. Andhra Pradesh is likely to achieve replacement level of fertility in the next two years. The State has shown a steep decline in fertility in spite of relatively lower age at marriage, low literacy and poorer outreach of primary health care infrastructure. In the North-eastern States of Tripura, Manipur, Mizoram there is substantial difficulty in accessing primary health care facilities, but these States have achieved not only low fertility rates but also low infant mortality, suggesting thereby that a literate aware population can successfully overcome difficulties in access to and availability of primary health care infrastructure. Even in the States with poor health indices, there are districts where the level of health indices are comparable to the national level. It would therefore appear that in the Indian context the decision of the families about their health and fertility is a critical determinant of demographic and health indices.

Implication Of The Projected Changes In Age Structure:

125. The population in the 15-59 age group will increase from 519 to 800 million; there will be no increase in the under 15 population in these two decades (353 million in 1996 to 350 in 2016; the population over 60 will nearly double from 62 to 113 million. For India the current phase of the demographic transition is both a challenge and an opportunity. In the next two decades the population growth will be mainly among the adolescents and young adults who will be more literate, aware and are likely to make optimal use of available facilities. The challenge is to ensure skill development, appropriate employment with adequate emoluments. If the challenge is met we may have the opportunity to utilise abundant human resources to achieve rapid economic development and improvement in quality of life. The current high population growth rate is due to:

- the large size of the population in the reproductive age-group (estimated contribution 60 per cent);
- higher fertility due to unmet need for contraception (estimated contribution 20 per cent); and
- high wanted fertility due to prevailing high IMR (estimated contribution about 20 per cent).

Ninth Plan aims to meet all the unmet needs for contraception and reduce IMR.

FAMILY WELFARE PROGRAMME IN THE NINTH PLAN

126. Reduction in population growth rate is one of the major objectives of the Ninth Plan. Ninth Plan envisages a paradigm shift in the FW programme. The Plan proposes to meet all the felt needs of the family and enable them to achieve their reproductive goals. If

this were done the families will ensure that the national goal of rapid population stabilisation. Ninth Plan envisages a paradigm shift from:

- Demographic targets to focus on enabling the couples to achieve their reproductive goals.
- Method specific contraceptive targets to meeting all the unmet needs for contraception to reduce unwanted pregnancies.
- Numerous vertical programmes for family planning and maternal child health to integrated health care for women and children.
- Centrally defined targets to community need assessment and decentralised area specific microplanning and implementation of reproductive and child health care (RCH) programme to reduce Infant mortality and reduce high desired fertility.
- Quantitative coverage to emphasis on quality and content of care.
- Predominantly women centred programme to meeting the families health care needs with emphasis on involvement of men in Planned Parenthood.
- Supply driven service delivery to need and demand driven service; improved logistics for ensuring adequate and timely supplies to met the needs.
- Service provision based on providers perception to addressing choices and conveniences of the couples.

127. During the Ninth Plan period efforts will be intensified to enhance the quality and coverage of family welfare services through:

- Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of ISM&H;
- Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral coordination and community participation in planning, monitoring and management;
- Involvement of the industries, organised and unorganised sectors, agriculture workers and labour representatives.

128. Efforts are being made to provide adequate inputs to improve availability and access to services to improve performance so that the disparities between states will be narrowed. It is noteworthy that there are districts in these states where CBR and IMR are well below the national levels; steps may have to be initiated to study and replicate these success stories within each of these states so that the existing disparities between states are minimised.

NATIONAL POPULATION POLICY 2000

129. One of the major recommendations of the NDC Sub Committee on Population was that a National Population Policy (NPP) should be drawn up so that it provides reliable and relevant policy frame work not only for improving Family Welfare Services but also for measuring and monitoring the delivery of family welfare services and demographic impact in the new millennium. The Department of Family Welfare has drawn up the National Population Policy 2000. The NPP has been approved by the Cabinet.

130. One of the major objectives of the Policy is that the country should achieve replacement level of fertility by 2010 and population stabilisation by 2045. The National Population Policy 2000 has set the following goals:

- Universal access to quality contraceptive services in order to lower the Total Fertility Rate to 2.1 and attaining two-child norm.
- Full coverage of registration of births, deaths and marriage and pregnancy.
- Universal access to information/counselling and services for fertility regulation and conception with a wide basket of choices.
- Infant Mortality Rate to reduce below 30 per thousand live births and sharp reduction in the incidence of low birth weight (below 2.5 kg.) babies.
- Universal immunisation of children against vaccine preventable diseases, elimination of Polio by 2000 and near elimination of Tetanus and Measles.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80 per cent institutional deliveries and increase in the percentage of deliveries conducted by trained persons to 100 per cent.
- Containment of Sexually Transmitted Diseases.
- Reduction in Maternal Mortality Rate to less than 100 per one-lakh live births.
- Universalisation of primary education and reduction in the drop out rates at primary and secondary levels to below 20 per cent both for boys and girls.

NATIONAL COMMISSION ON POPULATION

131. India has reached one billion population on 11th May 2000. On that day Prime Minister announced the formation of the National Population Commission with Prime Minister as the chairman and Deputy Chairman Planning Commission as Vice Chairman. Chief Ministers of all states, Ministers of the related Central Ministries, Secretaries of the concerned Departments eminent physicians, demographers and the representatives of the civil society are Members of the Commission. The Commission has the mandate:

- To review, monitor and give direction for implementation of the National Population Policy with the view to achieve the goals set in the Population Policy.
- Promote synergy between health, educational environmental and developmental programmes so as to hasten population stabilisation.
- Promote inter sectoral coordination in planning and implementation of the programmes through different sectors and agencies in Centre and the States.
- Develop a vigorous peoples programme to support this national effort.

MATERNITY BENEFIT SCHEME

132. The Group of Ministers constituted by the Cabinet Secretariat to look into the draft National Population Policy had recommended that the Maternity Benefit Scheme being implemented by the Department of Rural Development may be transferred to the Department of Family Welfare. The two departments involved have been requested to initiate necessary action for the early transfer of the scheme.

STRENGTHENING OF RURAL SUB-CENTRES UNDER NATIONAL HUMAN DEVELOPMENT INITIATIVE MEASURE

133. The Finance Minister in his Budget Speech for 1999-2000 announced a scheme for Strengthening the Rural Infrastructure by sharing responsibilities between the Panchayat, the State Governments and the Central Government for promoting Primary Health Care. In the structure of Primary Health Care, the Rural Sub-centres are the only institution which corresponds to the level of Panchayat. Therefore it is proposed to strengthen the sub-centres, funds for which will be contributed by the Central Government, State Governments and the Panchayats in the ratio of 2:2:1. The scheme envisages assistance to the State Governments and through them to the Panchayats for opening new centres in areas where the existing centres are already overloaded due to large area assigned to it and for strengthening the existing one with building and equipment. The Department of Family Welfare had earlier proposed an outlay of Rs.48 crore for the schemes which was later reduced by the Department to Rs.1 crore as a token provision. Since the scheme was not sent to Planning Commission for approval the Commission did not provide any allocation for the scheme.

INTERSECTORAL COORDINATION AND CONVERGENCE OF SERVICES

134. Effective implementation of Family Welfare Programme involves a great deal of inter-sectoral coordination. The related sectors have to take steps to enhance the status of women, particularly women's literacy and employment, to raise age at marriage, their general development, generating more income in rural areas. The Departments whose activities have close linkages with Family Welfare Programmes are the Department of Women and Child Development, Human Resource Development, Rural Development, Urban Development, Labour, Railways, Industry and Agriculture. All these Departments may involve their extension workers in propagating IEC messages pertaining to reproductive and child health care to the population with whom they work. Concerned Central and state departments like Department of Women & Child Development, Human Resources Development, Rural Development etc. may take steps to improve the status of girl child and of women, improving female literacy and employment, raising the age at marriage, generating more income in rural areas. Some of areas of inter-sectoral coordination are indicated below.

Department Of Education

- Involve all districts Saksharata Samitis in IEC activities pertaining to RCH Programme.
- As a part of socially useful productive work involve school teachers and children in Class V and above in growth monitoring, immunisation and related activities in the village at least once a month.

Women And Child Development

- Involvement of Anganwadi workers in compilation of local events such as births, deaths, identification of pregnant women and in recording of birth weights.
- Utilisation of Anganwadi worker in improving coverage of massive dose Vitamin-A in children and improving compliance in Iron-folic acid medication in pregnant women.

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- Identification of undernourished pregnant & lactating women and children below 5 years to ensure that these vulnerable populations get benefit of the food supplementation programmes under ICDS.
- In coordination with members of Panchayati Raj Institutions and agricultural extension workers to promote growing of adequate quantities of green leafy vegetables, herbs and condiments and ensure that these are supplied to anganwadies on a regular basis so that food supplements have also the vitamin and mineral contents.

Rural Development

- With the cooperation from Panchayati Raj Institutions utilise JRY for construction and maintenance of Primary health care institutions specially sub-centres and PHCs.

Rural Water Supply and Sanitation

- Explore feasibility of providing access to safe drinking water and sanitary disposal of wastes in primary health care institutions, Anganwadi, primary schools and panchayats on a priority basis through existing programmes.

Others

- Coordination among village-level functionaries – namely Anganwadi workers, Mahila Swasthaya Sangh (MSS), Traditional Birth Attendant (TBA), Krishi Vigyan Kendra (KVK) Volunteers, School teachers to achieve optimal utilisation of available services.

URBAN HEALTH AND FAMILY WELFARE SERVICES

135. Nearly 30 per cent of India's population lives in urban areas. Urban migration over the last decade has resulted in rapid growth of people living in urban slums. The massive inflow of the population has also resulted in the deterioration of living conditions in the cities. In many towns and cities the health status of urban slum dwellers is worse than that of the rural population. The Department of Family Welfare has been trying to extend the family welfare services to the urban population. Department of Family Welfare is supporting a network of urban family welfare centres with the objective of extending the family welfare services. Besides, externally aided projects like IPP-VIII were aimed to provide the family welfare services to the urban population in selected cities. Similarly, the urban component of externally aided Reproductive and Child Health Care (RCH) Programme provides family welfare services to the urban population.

136. The infrastructure for providing primary health care facilities to the urban population has not been established and a conscious effort need to be made for this. This health care infrastructure will also help in improving the outreach of family welfare services in the urban areas. The state health sector plan programmes should aim to develop the requisite infrastructure in the urban areas. The local bodies like municipalities/municipal corporations should supplement the efforts of the state Governments and the Central Government in this regard.

INVOLVEMENT OF LOCAL SELF-GOVERNMENT INSTITUTIONS

137. With the 73rd and 74th Constitutional amendments the Nagar Palikas and Panchayati Raj Institutions, are becoming operational in many States. These institutions should play increasing role in ensuring planning, implementation and monitoring of health and family welfare services at the local level. They should also ensure effective coordination of programmes at the local level between related sectors such as sanitation, safe drinking water and women and child development, so that optimal benefit from all these programmes become available to the community and the vulnerable segments receive the attention that they need.

INVOLVEMENT OF NON-GOVERNMENTAL ORGANISATIONS AND VOLUNTARY ORGANISATION FOR PROMOTION OF FAMILY WELFARE

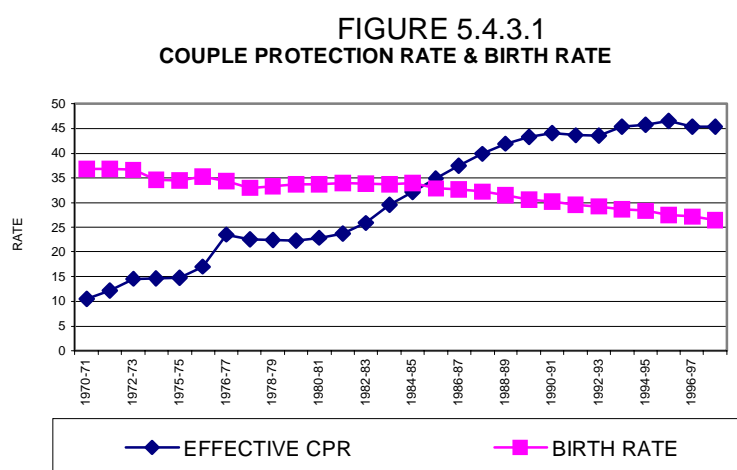
138. The Ministry of Health & Family Welfare has initiated several programmes involving Non-Governmental Organisations (NGOs) in efforts to improve Family Welfare Programme. These include:

- (i) revamping of Mini Family Welfare Centre in areas where the couple protection rates are below 35 percent;
- (ii) involvement of ISM & H practitioners;
- (iii) area-specific IEC activities through NGOs;
- (iv) establishment of Standing Committees for Voluntary Action (SCOVAs) to fund NGO projects promptly;
- (v) identification of Government/NGO organisations for training of NGOs in project formulation, programme management and monitoring.

These activities were continued and intensified during the 2000-2001.

Performance Of The Family Welfare Programme

139. Information on CPR and CBR indicate that there has been a steady decline in



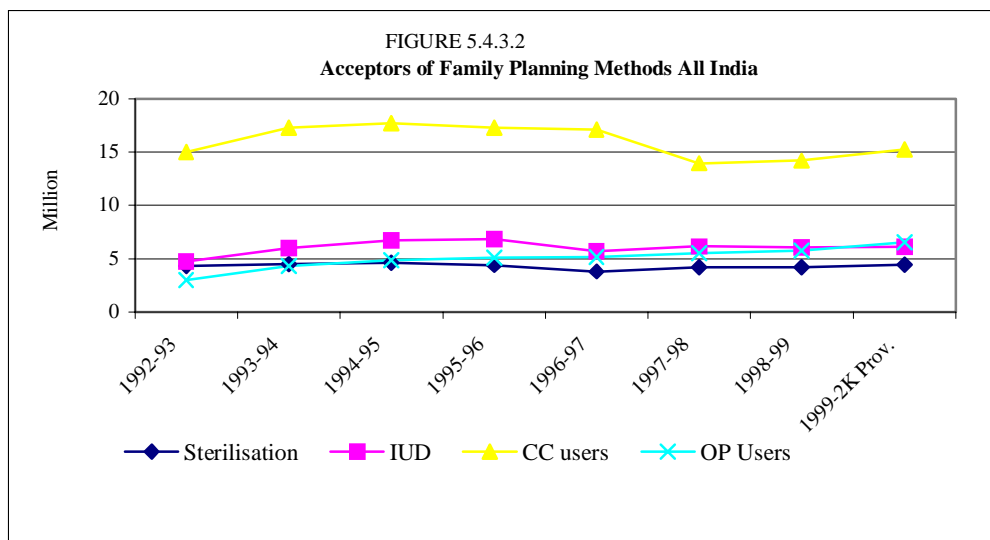
Source:- Registrar General India

Department of Family Welfare

the CBR during the Nineties in spite of the fact that the rise in CPR during the nineties has been very slow (Figure 5.4.3.1). This may indicate that there has been improvement in the

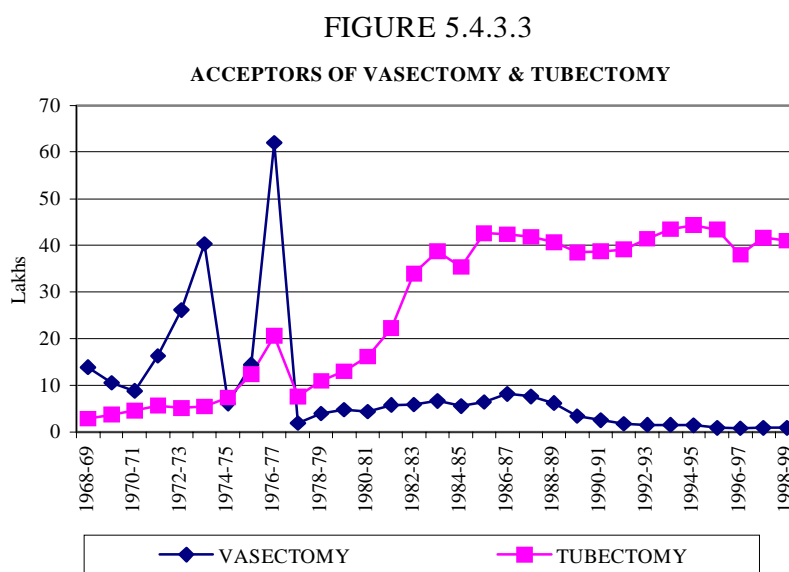
quality of services being provided and appropriate contraceptives are being provided at appropriate time. It is essential that there should be further improvement in providing counselling and quality of services to enable couples to make the appropriate choice; improvement in follow up care appropriate will go a long way in improving continued use of contraceptives to avoid unwanted pregnancies.

140. Data from service reports during the Ninth Plan period indicate that there has been a decline in acceptors of all family Planning methods except IUD as compared to the level of



acceptance in 1994-95 (Figure 5.4.3.2). Sterilisation remains to be the most commonly used method of contraception in all states. During the year 1999-2000 the acceptors of sterilisation have shown an increase of 6.3 per cent over the year 1998-99. The major states that have shown significant increase in the acceptors of sterilisation are Assam, Madhya Pradesh, Bihar, Kerala, Tamil Nadu, Punjab, Uttar Pradesh and Maharashtra. The number of sterilisations per ten thousand unsterilised couples varies considerably amongst the States. Andhra Pradesh has highest (939) sterilisations per ten thousand unsterilised couples while Assam has the lowest (76) sterilisations. The States, which are having lower number of sterilisations per ten thousand unsterilised couples as compared to all India average of 372, are Bihar (106), Orissa (252), Rajasthan (310), Uttar Pradesh (164) and West Bengal (282).

141. There had been a steady and progressive decline in the acceptors of vasectomy over the last two decades (Figure 5.4.3.3). Efforts to re-popularise vasectomy, including IEC campaigns and training of surgeons persons in non-



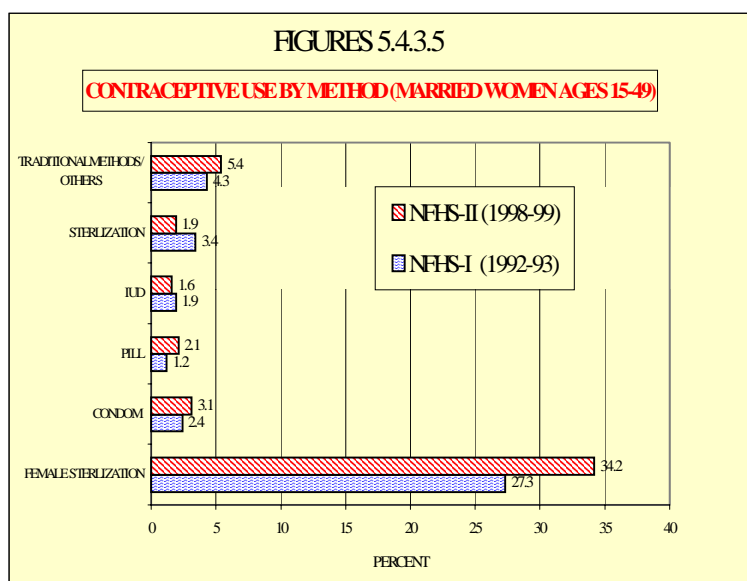
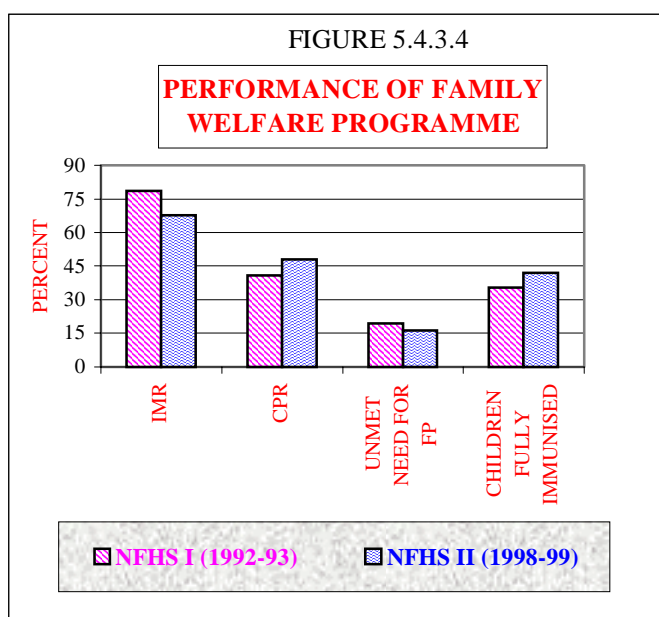
Source:- Department of Family Welfare

scalpel vasectomy has resulted in substantial increase in vasectomies in some districts in Andhra Pradesh; however, similar change has not happened at the national level. It is essential that the efforts to popularise vasectomy are continued by addressing the concerns and conveniences of men and improving the techniques and quality of vasectomy services. This would result not only in improving men's participation in the FW programme but also result in substantial increase in access to sterilisation services, reduction in the morbidity and mortality associated with sterilisation.

142. IUD acceptors have shown only a marginal increase during the year 1999-2000 as compared to 1998-99. The major states that have shown significant improvement in the acceptance of IUD are Assam and Karnataka. The states of West Bengal, Orissa, Maharashtra, Andhra Pradesh and Madhya Pradesh have shown a decline in performance during the year 1999-2000.

143. The acceptors of oral pill users have increased by 13.6 per cent during the year 1999-2000 as compared to the previous year. Among major states Punjab, Tamil Nadu, Uttar Pradesh, Madhya Pradesh, Haryana and Assam have shown an improvement in performance. The states of Bihar, Andhra Pradesh, West Bengal, Kerala and Karnataka have shown a decline in performance. CC users have shown an increase of 7.1 per cent during the year 1999-2000 as compared to the year 1998-99. All the major States except Tamil Nadu have shown a decline in CC users.

144. The National Family Health Survey 1992-93 and 1998-99 provide nationwide data on contraceptive prevalence (Figure 5.4.3.4 & 5.4.3.5).



Data from the Survey indicate that contrary to the figures from the service reports from the Department of Family Welfare there has been substantial increase in the sterilisation and OC use in the country. Only IUD and CC use have shown a decline. The reported improvement is supported by the steady decline in the CBR in the nineties reported in the SRS.

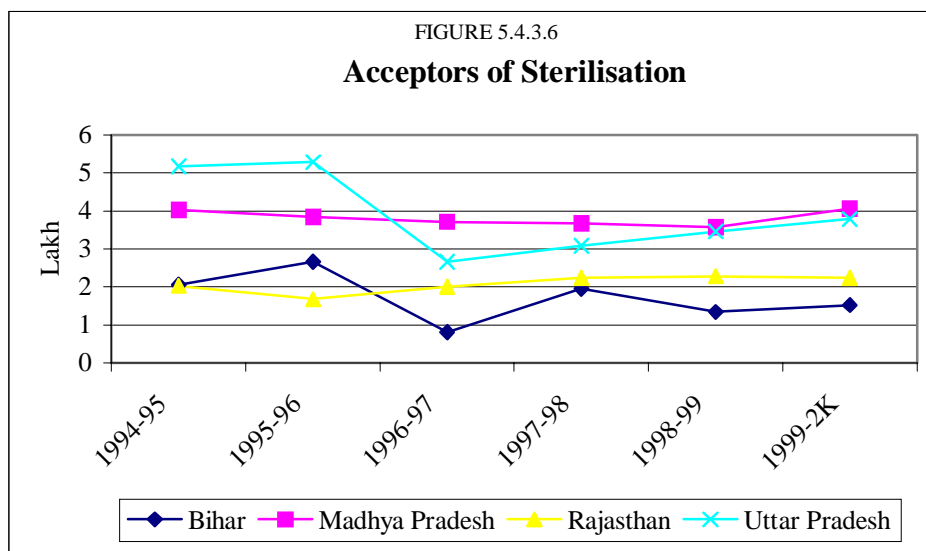
145. The reasons for the difference in the CPR figure reported by the Department of Family Welfare and NFHS include the following:

- (i) Correction of the earlier over reporting in an attempt to reach the set target.
- (ii) Incomplete reporting due to changes in reporting under the Family Welfare Programme during the period.

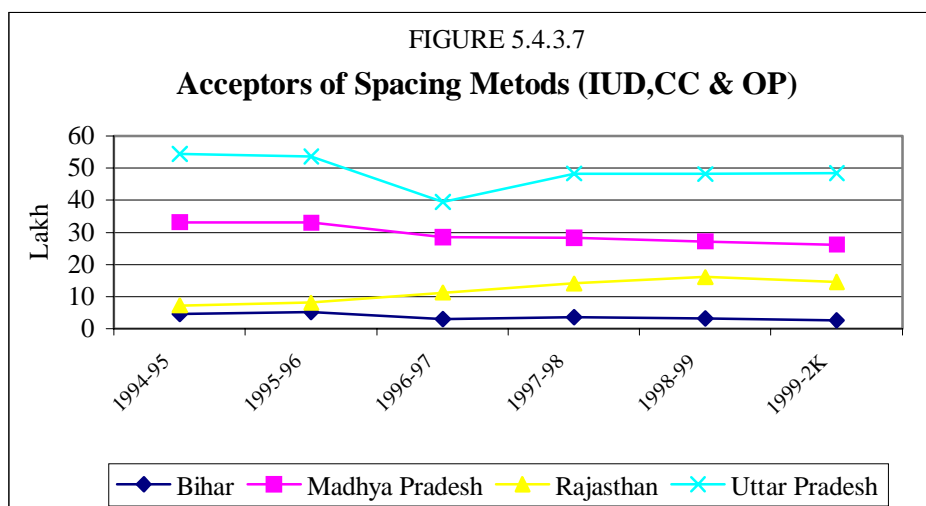
These need to be looked into and corrected so that service reporting provide reliable indication of progress achieved in the programme.

PERFORMANCE OF THE STATES WITH LARGE UNMET NEEDS

146. It is a matter of concern that in UP and Bihar, as compared to their own



performance in 1994-95, there is a fall in the acceptance of all contraceptive methods. In MP, the decline is marginal while Rajasthan has shown some improvement. It is essential



that efforts to meet all unmet needs for contraception in these States are made. There are however districts with low CBR in all these States. The States have to study and replicate the performance of these districts; simultaneously there should be efforts to meet all the unmet needs for contraception in all districts.

PERFORMANCE UNDER THE IMMUNISATION PROGRAMME

147. Immunisation coverage during the period 1992-93 to 1999-2000 is shown in

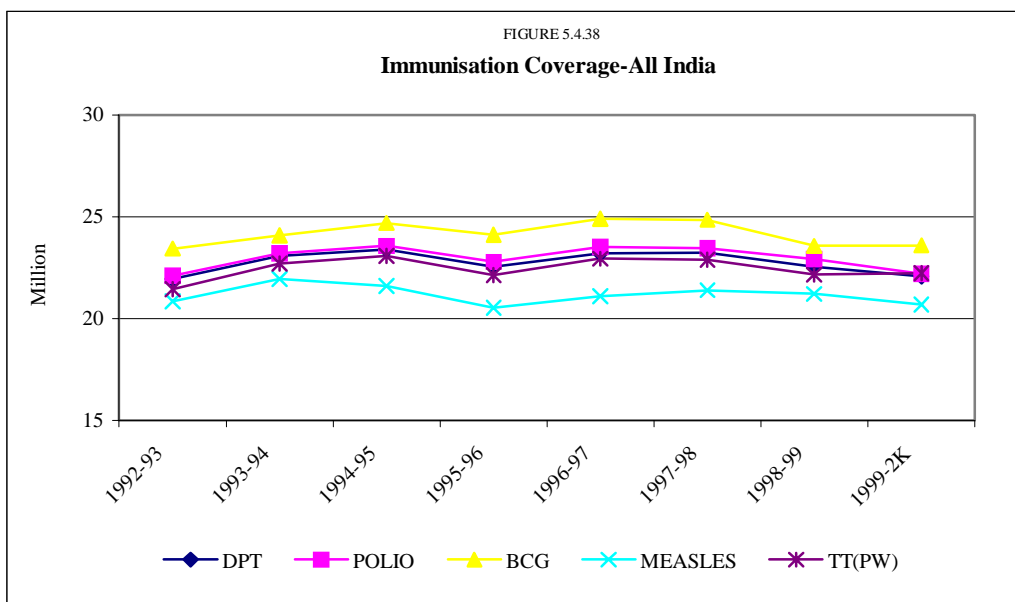
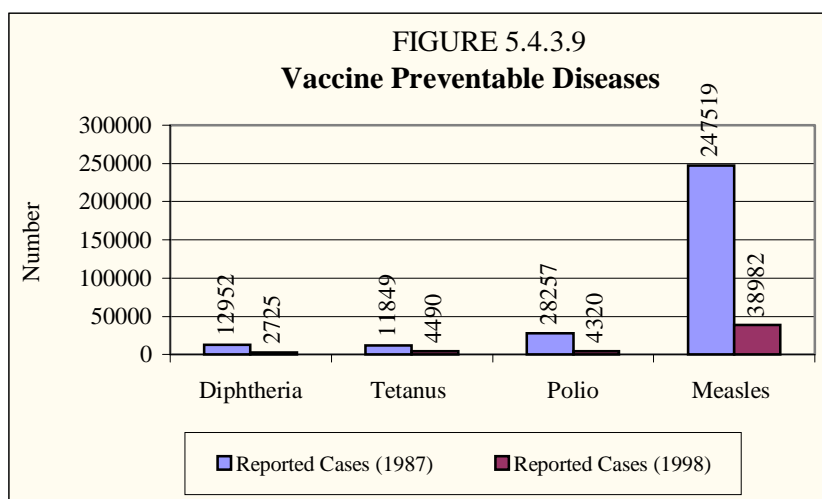


Figure 5.4.3.8. It is obvious that the Eighth Plan target of 100 per cent coverage for all six Vaccine Preventable Diseases (VPD) has not been achieved even by 2000 AD. The immunisation coverage has been stagnating at the same level throughout the nineties in most of the states and in some of the states even the declining trend is being observed. However, it is noteworthy that the reported cases of vaccine preventable diseases have declined over the same period. (Figure 5.4.3.9).

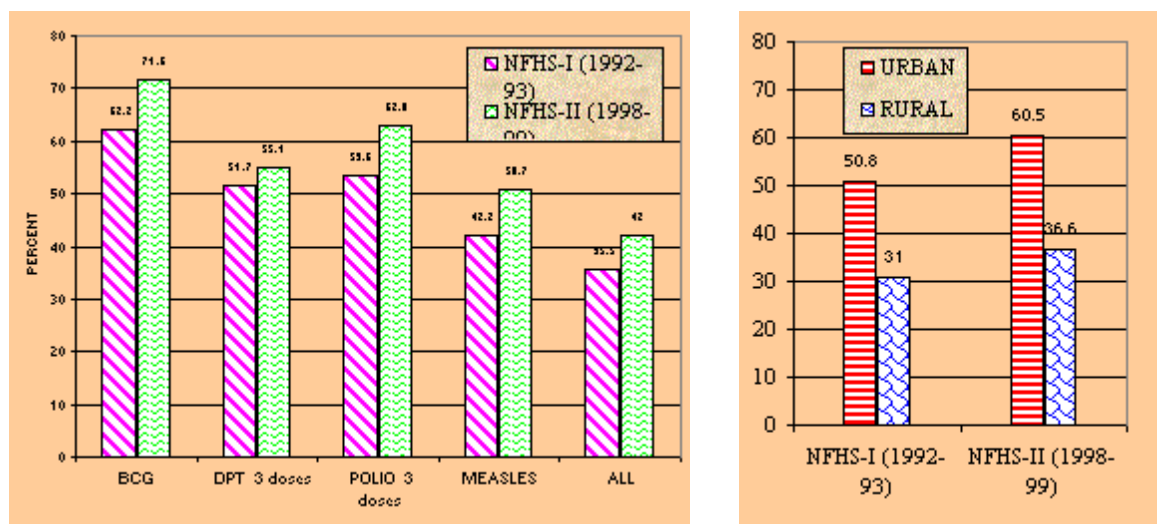
The coverage evaluation survey conducted by ICMR and National Family Health Survey shows a wide gap between the reported and evaluated coverage. The drop out rates between the first, second and third doses of oral polio vaccine and DPT have been very high in most of the states. At the national level, the difference



between the highest and lowest covered antigens is more than 20 per cent. The difference between the reported and evaluated coverage and high drop out rates is of serious concern. The data from the NFHS-I & II has shown that even though coverage under immunisation programme is substantially lower than the coverage figure reported by service providers;

however, there has been some improvement in the immunisation coverage (Figure 5.4.3.10). It is essential that all efforts be made to ensure 100 per cent coverage under vaccine preventable diseases.

Figure-5.4.2.10
IMMUNISATION OF CHILDREN 12-23 MONTHS : NFHS-I (1992-93) AND NFHS-II (1998-99)



Pulse Polio Initiative

148. Pulse Polio initiation was taken up by the Department of Family Welfare in 1995 with the objective of achieving elimination of polio by 2000 AD. Initially, the programme consisted of two rounds of pulse polio immunisation of children below 5 years of age during the months of December and January. Since 1995 there has been significant decline in number of reported polio cases from 28257 reported in 1987 to 2810 in 1999; but the reduction was not of the magnitude as to achieve the target of elimination of polio by 2000 AD.

149. The programme was reviewed by the Department of Family Welfare in 1998-99. Following the review and expert advice from national and international agencies, the Department took up four rounds of pulse polio immunisation throughout the country with two additional rounds in eight states with high polio case load for the year 1999-2000. Special efforts were made to cover all the unreached children through a house to house survey after the initial booth based immunisation. Reported coverage levels both in urban and rural areas was high, near 100 per cent even in the districts with poor infrastructure. There were however reports of decline in the routine immunisation in many States; some States like Bihar reported routine immunisation coverage fall below 40 per cent. There were also concerns that routine maternal and child health service coverage was adversely affected in some States.

150. The map at Annexure 5.4.3.1 clearly indicates that in most part of the country over the last three years there has been significant decline in number of polio cases; the decline is sub-optimal in States of Delhi, Uttar Pradesh, Bihar and West Bengal. Many States like Kerala, HP, Jammu & Kashmir and north eastern States have not reported any case

during last 2-3 years. During 1999 Orissa has also joined these states and not reporting any case even though there was outbreak in Ganjam district in 1998. The major states like Tamil Nadu, Andhra Pradesh, Rajasthan, Haryana, Punjab have not reported as yet any confirmed case during 2000.

151. The Department of Family Welfare has come up with the revised proposal for pulse polio immunisation during 2000-01 that there will be two rounds of NIDs throughout the country in December and January; one additional round will be given in six States where cases of polio have been reported in 1999-2000 and two additional rounds in the States of UP, Bihar, West Bengal and Delhi which account for over 80 per cent of cases of polio reported in the country. Every effort will have to be made to ensure that the near 100 per cent coverage both during routine immunisation and the pulse polio rounds.

152. In spite of severe global shortage of oral polio vaccine, India has been able to persuade UNICEF, WHO and global manufacturers to provide the necessary vaccine during 1999-2000. With the goal to achieve polio eradication by the end of year 2000, all the other endemic countries have accelerated their efforts and during 2000-2001, there would be severe shortage of vaccine globally. It will be important for all the states to minimise the wastage rate which is 25 per cent at present and exercise strict monitoring to control any unwanted wastage. It would be important also to retrieve unused vaccine from the periphery which is more than their requirement for routine immunisation programme and store them at appropriate place with adequate cold-chain facility.

153. There is also a need to identify the areas of low coverage so as to intensify PPI activities in such areas. Near hundred per cent coverage of children for providing OPV both during routine immunisation and PPI is critical to achieve and sustain the goal of elimination of polio. The States and UTs should identify at a micro level, areas with low routine coverage, areas with low PPI coverage etc. to intensify immunisation activities and extending the outreach of services in these areas.

POLIO SURVEILLANCE

154. Efficient surveillance is essential for all disease control programmes. The Department has strengthened the surveillance for polio and achieved substantial improvement in the reporting of cases. The programme is being extended to cover other vaccine preventable diseases. This in turn should be integrated with the ongoing disease surveillance programme being funded by the Department of Health so that over the next five years the country builds up a sustainable disease surveillance and response system.

155. The district wise surveillance data for the year 1998 and 1999 shows that there are large number of districts which have low surveillance indicators and would therefore require special attention in improving surveillance system at the earliest. The data also needs to be used in developing the action plan for identifying high risk districts and blocks in the State. In Andhra Pradesh, the districts of Chittoor and Warangal needs special attention to improve the surveillance system. In Assam, the districts of Barpeta and Bongaigaum, Nalbari and Shibsagar have reported non polio AFP rate less than 1. It is essential that polio surveillance is strengthened further and all cases are detected. It is important that along with this, there is an effort to improve the surveillance against all six vaccine preventable diseases. It is also important that linkages are developed with the ongoing national initiative on disease

surveillance so that within the next five years a reliable disease surveillance and monitoring mechanism is built up.

PPI EVALUATION

156. The Department of Family Welfare has carried out independent coverage evaluation surveys for the immunisation programme and the pulse polio initiative. The coverage evaluation survey report indicate that the actual coverage is substantially lower than the figures reported through service channels. It is imperative that steps are taken to improve coverage both under the routine immunisation and under pulse polio immunisation.

EVALUATION OF RCH PROGRAMME

157. Monitoring indicators do not provide any information on the quality of care or appropriateness of the services. The programme must evaluate 'quality of care' of the services being provided. Efforts should be made to collate and analyse service data collected at the district level and respond rapidly to the evolving situations. Available data from census, demographic and health surveys undertaken in the district by various agencies including the Population Research Centres needs to be analysed and utilised at the local level for area-specific micro planing. The Department of Family Welfare has constituted regional evaluation teams which carry out regular verifications and validate the acceptance of various contraceptives. Besides, the information generated through ad hoc surveys such as National Family Health Survey (NFHS) must also be utilised to identify the shortcomings of the programme and to initiate requisite remedial measures. The Department of Family Welfare has completed rapid household surveys under RCH project in about fifty per cent of the districts during the year 1998-99 and 1999-2000. The main focus of the survey was on estimating coverage under ante-natal care and immunisation, proportion of safe deliveries, contraceptive prevalence rate, unmet need for family planning, utilisation of health/family welfare services and users satisfactions. The information collected provided useful feed-back for evaluation of the implementation of the programme. The census reports, studies conducted through Population Research Centres, ad hoc surveys and district surveys under RCH provide data for evaluating the impact of the programme. The data generated through these reports and surveys should be utilised to evaluate the family welfare programme at the PHC level.

DISTRICT FACILITY SURVEYS

158. To assess the availability and utilisation of facilities in various health institutions in the country, district-wide facility surveys have been initiated. Information is collected from district hospitals/sub-divisional level hospitals/CHCs/PHCs. Reports from about 240 districts have been received. The survey results are being analysed and disseminated to the respective districts as well as the State governments for remedial measures.

DISTRICT SURVEYS

159. District surveys have been initiated by the Department of Family Welfare with the objective of ascertaining the status of individual component of RCH programme. Under these surveys, a sample of 1000 households in every district will be selected to ascertain which RCH facilities are reaching the people and to what extent. Half the districts are being taken up every year. In the first phase, the survey was conducted in 270 districts by

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independent agencies under the aegis of IIPS during 1998-99. In 1999-2000, survey in another 250 districts has been completed. The reports are being made available to the respective State Governments. Workshops were also arranged with the help of Regional Family Welfare Centres and State Institute of Health & Family Welfare so that the action points emerging out of the reports are implemented. The salient results of the second phase of survey are given below:

- The districts having the higher order of birth less than 20 per cent, are observed in 5 districts out of 7 districts in Kerala, two out of ten in Karnataka, one out of eleven in Tamil Nadu, one in Goa (all), and one out of two in Pondicherry, out of 253 districts surveyed.
- The per cent of pregnant women who had IFA tablets is more than 74 per cent, are in respect of only 37 districts out of 253 surveyed; these are 5 districts in Andhra Pradesh, one in Gujarat, 6 each in Karnataka and Kerala, 5 in Maharashtra, 2 in Tamil Nadu in major states. 50 to 75 per cent coverage was observed in 75 districts in the country. The IFA tablets coverage is weak in many States, especially in Bihar, MP, Rajasthan and UP where more than 50 per cent of the districts had a coverage of IFA tablets of less than 30 per cent.
- The National Programme provides for three ante-natal check up to take care of complicated pregnancies/deliveries. The districts in States had more than 75 per cent pregnant women had undertaken 3 ante natal check up are mainly AP (almost all), Karnataka (80 per cent), Kerala (all), Tamil Nadu (all). In the country only about 18 of the districts have more than 75 per cent of the pregnant women had all 3 ANCs.
- Only 9 per cent of the districts had more than 75 per cent of the deliveries conducted in hospitals out of 253 districts surveyed in 2nd phase. The States are mainly Kerala (all), Tamil Nadu (9 out of 11) and Pondicherry (1 out of 2). The States where less than 30 per cent deliveries were conducted in hospitals are Assam, Bihar, Haryana, MP, Orissa, Rajasthan and UP amongst major States. At all India level, in 57 per cent of the districts, institutional deliveries have been less than 30 per cent.
- The usage of ORS packets was inadequate with no districts reporting usage of ORS packets in more than 75 per cent of the cases of diarrhoea in the country. 87 per cent of the districts reported usage of ORS in less than 25 per cent of the episodes of diarrhoea.
- The percentage of children who have been fully immunised with 3 doses of Polio, 3 doses of BCG, Measles and DPT have been more than 75 per cent in only 27 per cent of the districts.
- The widely accepted method in family planning, sterilisation has been highly accepted in the states of Andhra Pradesh, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Tamil Nadu.

FUNDING OF FAMILY WELFARE PROGRAMME

Financing Of Non-Plan Activities Through The Plan Funds

160. Family welfare programme is an important programme and was initiated as a plan scheme so that adequate attention is paid with regard to positioning of requisite manpower at various health care delivery institutions. The programme is a hundred per cent centrally

sponsored programme and is being implemented through the State Governments. The Department of Family Welfare provides funds to the State Governments for the maintenance of health and family welfare infrastructure and implementation of the programme according to certain fixed norms. The plan funds of the Department of Family Welfare are being utilised for meeting the expenditure on the programme activities such as salaries, recurrent provision for rent, medicines, contingencies etc. which are essentially non-plan in nature. This committed non-plan expenditure on salaries and maintenance of infrastructure leaves the Department of Family Welfare with no funds to take up any new innovative programmes. Department of Family Welfare has requested the Finance Commission for transfer of the non-plan activities to the Non Plan side. Planning Commission has also supported the request of the Department in this regard. The decision of the Finance Commission is awaited.

The Problem Of Arrears, Need For Reorganisation Of The Programme And Involvement Of States

161. The Department of Family Welfare provides funds for the maintenance of 97,757 sub-centres out of 1,36,339 functioning sub-centres. Planning Commission had repeatedly emphasised the need for financing all the functioning sub-centres so that the ANMs which are crucial peripheral workers for implementation of the Family Welfare Programme are in position at all the sub-centres. The Department of Family Welfare bears the cost of maintenance of rural family welfare sub-centres, Postpartum Centres, Urban Family Welfare Services and training activities according to certain norms which were fixed long back. There is a wide gap between the actual funds required to maintain the above services and the funds being provided according to the norms. Thus, it results in the accumulation of arrears payable to the States. The delay in the payment of arrears to the states adversely affects the family welfare services in all the states especially those with fiscal problems; many of these States such as Bihar, UP, MP and Rajasthan are also the ones who have made all efforts to improve performance in family welfare programme. In view of this the Planning Commission had suggested that there is an urgent need to review the norms for providing funds to the states for implementation of the family welfare programmes.

162. As suggested by the Planning Commission, the Department of Family Welfare constituted a Consultative Committee to review these norms, evolve realistic norms for salary, contingency and other expenses for different types of infrastructure and manpower funded by the Department of Family Welfare. The Consultative Committee constituted by the Department of Family Welfare to revise norms has also looked into rationalisation of infrastructure and manpower created in rural and urban areas so that Centre and states both fund the relevant portions of the programme. The Department of Family Welfare has circulated draft report of the Committee to the States for their comments; it is expected that the report will be finalised and the recommendations implemented in the current year.

EXTERNALLY AIDED PROJECTS

163. Area Development Projects have been taken up under National Family Welfare Programme in different States with financial assistance from external agencies such as the World Bank, United Nations Population Fund (UNFPA), Overseas Development Agency and Danish International Development Agency (DANIDA) with the objectives of reducing maternal and child mortality, morbidity and birth rate.

164. IPP VIII and IPP IX projects, Family Health Support Project in Maharashtra assisted by German Government, DANIDA Phase III Project in Tamil Nadu, ODA Phase III Project in Orissa and UNFPA assisted district projects in five districts of Kerala, Bihar, Maharashtra, Rajasthan and Himachal Pradesh would continue during 1999-2000. The USAID assisted project in UP would also continue during 2000-01 for which a provision of Rs.250 crore has been made.

REPRODUCTIVE AND CHILD HEALTH PROGRAMME

165. The CSSM and related programmes have been reorganised into Reproductive and Child Health (RCH) Programme. This programme seeks to integrate and expand family welfare services, upgrade their quality and make them easily accessible to the people. The essential feature of this programme is balanced and pointed attention to contraception issues, maternal health issues and child survival issues without leaving out any of their components unattended. Efforts are being made to improve the health status of women and children and thus ensure a decline in population growth. Focussed attention is being paid to improve the service delivery systems.

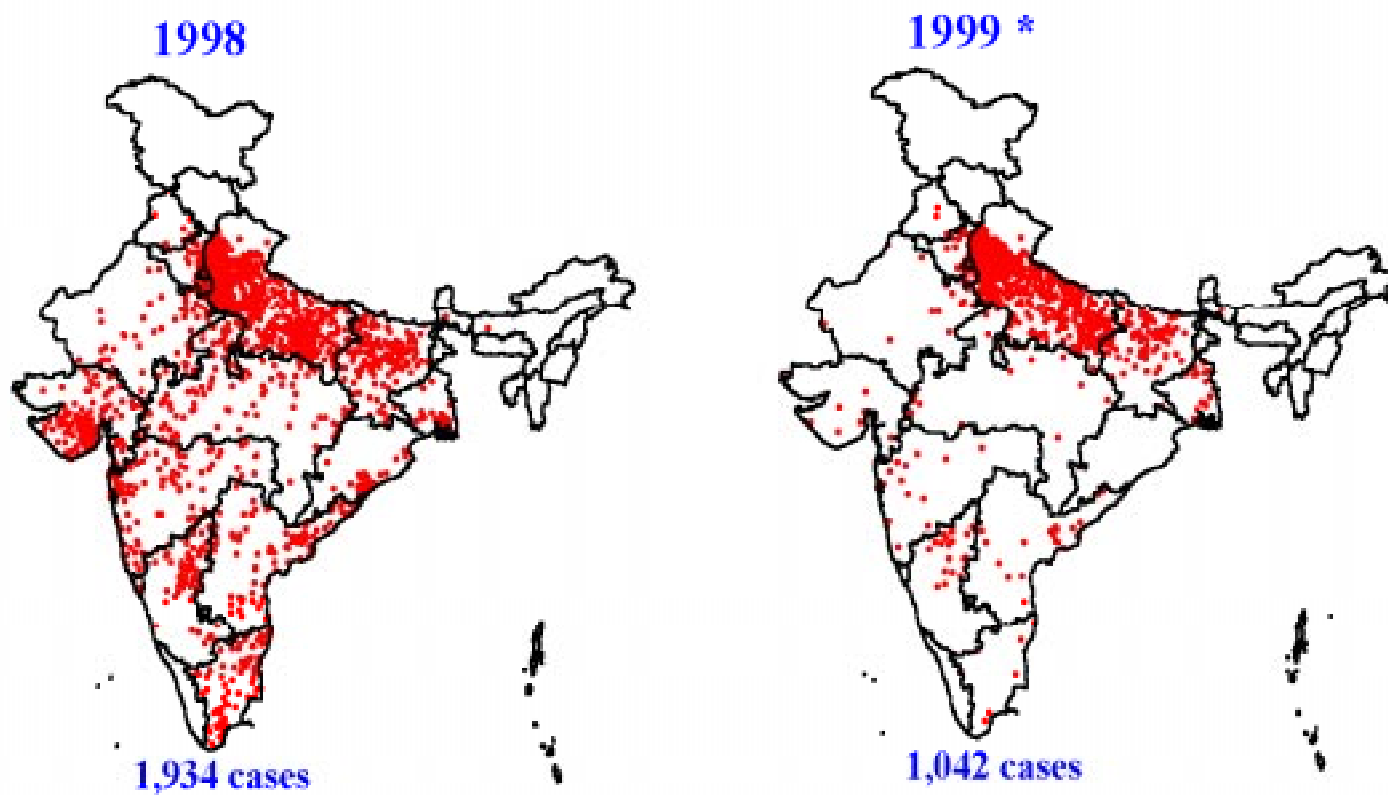
166. The total cost of the project which is to be implemented during the Ninth Plan period is Rs.5112 crore out of which Rs.3600 crore is expected to be the external assistance and the balance amount is to be provided by the Government of India for sustaining the on-going maternal and child health care activities and for counter part funding for the RCH Project. A provision of Rs.743 crore has been made for different programmes under RCH Programme for the Annual Plan 2000-01.

OUTLAYS FOR 2000-01

167. The outlay for Annual Plan 2000-01 the Department of Family Welfare is Rs.3520 crore. Planning Commission did not support the scheme of supply of mopeds to ANMs and observed that the evaluation of scheme must be completed so as to take a decision on continuation of the scheme during the future annual plans. The Planning Commission reduced the provision for the scheme of Supply/Procurement of Laproscopes in view of the fact that the evaluation studies have shown that laproscopic sterilisation at Camps settings is associated with higher morbidity. The provision for the scheme on procurement of cold chain equipment was reduced in view of the poor expenditure during the annual plan 1999-2000. The provision for the schemes RCH Contractual Staff & Services, Training Activity under RCH, Involvement of NGOs, IEC activities, Research Activities under RCH, Special Project for Tribal and Urban Slums and other RCH interventions was reduced in view of the fact that these programmes are being implemented for the last two years and outlays for these activities was felt to be de-escalated. Planning Commission approved an increased outlay under arrears so as to liquidate all the arrears payable to the States for implementing the family welfare programme as per the norms fixed by the Department of Family Welfare. The Group of Ministers constituted by the Cabinet Secretariat to make recommendations on the draft National Population Policy had recommended that the Maternity Benefit Scheme being now implemented by the Department of Rural Development be transferred to the Department of Family Welfare. Planning Commission had requested the Department of Rural Development and the Department of Family Welfare to initiate steps for early transfer of the scheme. A token provision of Rs.1 crore was approved by Planning Commission for the Maternity Benefit Scheme under the Annual Plan 2000-2001. The scheme-wise allocation of the approved outlay is shown in Annexure 5.4.3.2.

Locations of polio virus in India

1 dot = 1 case



* data as on 5th February 2000

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ANNEXURE 5.4.3.2

Department Of Family Welfare					
Annual Plan 2000-2001					
(Rs. in crore)					
Scheme	1999-2000 Approved outlay	1999-2000 Anticipated Expnd.	2000-2001 Proposed outlay	2000-2001 approved outlay	
				GBS	EAP
1	2	3	4	5	6
1 Rural Family Welfare Centres	350.00	350.00	637.00	375.00	
2 Sub-Centres	525.00	525.00	1102.00	575.00	
3 Maintenance of urban FW Centres	27.00	27.00	53.02	28.00	
4 Revamping of urban level organization	31.00	31.00	47.85	32.00	
5 Direction & Administration	185.50	115.50	171.00	116.00	
6 Sterilization beds	1.70	1.70	1.90	1.50	
7 Post Partum Centres	120.00	120.00	236.48	120.00	
8 Basic Training Schools	61.90	61.08	96.29	63.75	
9 Village Health Guides Scheme	10.00	10.00	10.00	10.00	
10 Sterilization and IUD insertion	140.00	110.00	162.00	120.00	
11 Community incentive scheme	0.00	0.00	108.00	0.00	
12 Transport	43.00	43.00	129.00	48.00	38.00
(a) Maintenance of vehicle already available	30.00	30.00	35.00	30.00	
(b) Procurement of vehicles to replace exiting	3.00	3.00	56.00	10.00	
(c) Supply of Mopeds to ANMs	10.00	10.00	38.00	8.00	8.00
13 Contraceptives	267.70	212.70	349.58	223.70	41.00
(a) Free distn. Of Conventional Contraceptive	50.00	50.00	108.00	50.00	
(b) Free Supply of Lippies, loops & Cu-T.	22.50	22.50	24.02	22.50	
(c) Free Supply of oral pills	15.00	15.00	14.00	15.00	
(d) Social marketing of contraceptives	140.00	105.00	127.59	106.00	20.00
(e) Supply /Procurement of Laparoscopes	20.00	20.00	30.00	10.00	
(f) Testing Facilities	0.20	0.20	0.25	0.20	
(g) No-Scalpel Vasectomy					1.00
(h) Logistics Improvement	20.00	0.00	45.72	20.00	20.00
14 Procurement of cold chain Equipment	50.00	0.00	38.17	20.00	
15 Hindustan Latex Ltd.	0.10	0.10	0.05	0.00	
16 Travel of Experts/Conferences /Meetings etc.	1.50	0.50	1.50	1.00	
17 Research Institutes	25.30	25.30	32.62	28.45	
18 International Contribution	1.30	1.30	1.60	1.60	
19 Information, Education and Communication	31.20	31.20	35.91	30.00	
20 Strengthening of National Immunization Programme and Eradication of Polio					45.00
21 Reproductive & Child Health Project	676.80	889.80	1505.81	715.00	1019.00
(a) Procurement of vaccines/equipment/drugs	325.00	555.00	702.00	475.00	
(b) RCH Contractual Staff and services	30.00	12.00	24.21	10.00	
(c) Training activities under RCH	50.00	25.00	50.00	20.00	
(d) Involvement of NGOs and SCOVA	26.00	20.00	34.50	15.00	
(e) Information, Education and Communication	88.80	138.80	167.60	80.00	
(f) Research Activities under RCH	20.00	14.00	21.50	10.00	
(g) Special Project for tribal and urban slums	12.00	0.00	41.00	5.00	
(h) Other RCH Interventions and services	100.00	100.00	405.00	50.00	
(i) RCH District Projects	25.00	25.00	75.00	50.00	
22 Area Project	100.00	130.00	367.00	250.00	200.00
23 USAID Assisted U.P.Project	70.00	70.00	70.00	60.00	60.00
24 Arrears	200.00	700.00	900.00	700.00	
25 FW Counsellor Scheme	2 1.00	0.00	0.00	0.00	
26 Maternity Benefit Scheme	0.00	0.00	0.00	1.00	
GRAND TOTAL	2920.00	3455.18	6056.78	3520.00	1403.00

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